

**X-RAY SUPERVISOR AND OPERATOR APPLICATION****Please read instructions on reverse before completing application. Print legibly. Complete all entries that apply to you.**

Last name		First name		Middle initial	Date of birth
Mailing address number		street name		apartment/suite number	Social security number
City		State	ZIP code		Home telephone number ( )
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	E-mail address		Fax number ( )		Work telephone number ( )

**NOTE: "All information on this application is releasable to the public. You may submit a P.O. box number rather than a home address if no other business address is available." California Public Records Act (PRA), Government Code, Sections 6250, et seq.**

Professional license number	Classification <input type="checkbox"/> M.D. <input type="checkbox"/> D.P.M. <input type="checkbox"/> D.C. <input type="checkbox"/> D.O.
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**NOTE: Application will not be acceptable without a copy of your current professional license.****Medical Specialty** (Check only one.)

- |  |  |   |
|--|--|---|
| 1. <input type="checkbox"/> Anesthesiologist             | 8. <input type="checkbox"/> Family Practice            | 15. <input type="checkbox"/> Pain Management    |
| 2. <input type="checkbox"/> Cardiology                   | 9. <input type="checkbox"/> Gastroenterology           | 16. <input type="checkbox"/> Pediatrics         |
| 3. <input type="checkbox"/> Chiropractic                 | 10. <input type="checkbox"/> General Practice          | 17. <input type="checkbox"/> Podiatry           |
| 4. <input type="checkbox"/> Dermatology                  | 11. <input type="checkbox"/> General Surgery           | 18. <input type="checkbox"/> Radiation Oncology |
| 5. <input type="checkbox"/> Diseases of the Chest        | 12. <input type="checkbox"/> Internal Medicine         | 19. <input type="checkbox"/> Radiology          |
| 6. <input type="checkbox"/> Emergency Medicine           | 13. <input type="checkbox"/> Obstetrics and Gynecology | 20. <input type="checkbox"/> Urology            |
| 7. <input type="checkbox"/> Eyes, Ears, Nose, and Throat | 14. <input type="checkbox"/> Orthopedics               | 21. <input type="checkbox"/> Other: _____       |

**Request for Permit**

- |   |  |
|---|--|
| <input type="checkbox"/> Radiography Supervisor and Operator Permit | <b>Previous RHB Permit number:</b> _____                                     |
| <input type="checkbox"/> Fluoroscopy Supervisor and Operator Permit |  |
| <input type="checkbox"/> Dermatology Supervisor and Operator Permit | <input type="checkbox"/> Limited Bone Density Supervisor and Operator Permit |

**Request for Certificate**

- |  |  |                       |
|--|--|-----------------------|
| <input type="checkbox"/> Radiology Supervisor and Operator Certificate (Radiologists only) |  |                       |
| <input type="checkbox"/> American Board of Radiology                                       | <input type="checkbox"/> American Osteopathic Board of Radiology | Date certified: _____ |

**X-Ray Equipment**Do you ☐ Own ☐ Possess (rent or lease) X-ray equipment? ☐ Yes ☐ No

If answer is yes, please indicate type of equipment you own or possess:

☐ Radiographic ☐ Fluoroscopic ☐ Other \_\_\_\_\_**Declaration****I certify that the foregoing is true and accurate.**

Signature of applicant	Date	<b>DEPARTMENT OF HEALTH SERVICES USE ONLY</b> Certificate number Classification code Date coded Coded by
<b>Mail application, supporting documents, and fee (see applicable fee schedule) to:</b>		
MAILING ADDRESS: Department of Health Services Radiologic Health Branch—Certification P.O. Box 942833, MS 178 Sacramento, CA 94234-2833	FOR EXPRESS DELIVERY ONLY: Department of Health Services Radiologic Health Branch—Certification 601 North Seventh Street, MS 178 Sacramento, CA 95814	

**X-RAY SUPERVISOR AND OPERATOR APPLICATION INSTRUCTIONS**  
**WEBSITE: [www.dhs.ca.gov/rhb](http://www.dhs.ca.gov/rhb)**

**Please submit all of the following to the Department of Health Services.**

1. Submit a completed **X-Ray Supervisor and Operator Application (RH 4038)**.
2. Submit the **APPLICATION FEE** of \$55.95, payable to **Department of Health Services**.
3. Submit the **TESTING FEE** of \$250 per examination, \$500 for two examinations, in the form of a **cashier's check or money order, payable to ARRT. (Personal checks will not be accepted.)**
4. Enclose a copy of your California medical/professional license, or a letter from a residency or fellowship program attesting enrollment status and estimated date of completion.
5. Submit all documents required for the certificate or permit requested.
6. Enclose three self-addressed labels.

**Caution:**

1. ARRT fees are **NONREFUNDABLE**
2. Do not submit this application unless you are ready to take the exam(s) within the next 90 days.
3. If your application is approved, you will receive information concerning a list of testing centers and scheduling instructions from the ARRT. **PLEASE READ CAREFULLY.**
4. **Study material** will be sent to you by RHB once you are approved.
5. If your application is **not approved**, RHB will inform you of the reason(s) in writing.

**REQUIREMENTS FOR ELIGIBILITY**

**Radiologist:** For a **Radiology Supervisor and Operator Certificate**, submit a copy of your California medical license and your American Board of Radiology (ABR) or American Osteopathic Board of Radiology (AOBR) certificate. Upon receipt of the required documentation, a Radiology Supervisor and Operator certificate will be issued. Board certified radiologists are exempt from taking the state radiation protection examination and therefore need only submit the application fee of \$55.95.

Residents and fellows in radiology programs must submit documentation attesting to their status and estimated date of completion on facility letterhead, and must take both the Fluoroscopy and Radiography examinations. A Radiology Certificate will be issued after passing BOTH the Fluoroscopy and Radiography examinations. NOTE: **Only one application fee of \$55.95 is required for a Radiology Certificate.**

**Nonradiologist (M.D., Chiropractor, Podiatrist, etc.) Radiography and/or Fluoroscopy Supervisor and Operator Permit**

1. **A Radiography Supervisor and Operator Permit is REQUIRED if you use or supervise a Radiologic Technologist or limited permit X-ray technician who uses radiography and ancillary equipment on human beings. This includes use of bone density machines (full body machines).**

The Radiography Supervisor and Operator Permit examination is a 1.5-hour examination consisting of 90 questions in radiography radiation protection and safety, and use of radiography and ancillary equipment.

2. **A Fluoroscopy Supervisor and Operator Permit is REQUIRED if you use or supervise a Radiologic Technologist who uses fluoroscopy and ancillary equipment on human beings.**

The Fluoroscopy Supervisor and Operator Permit examination is a 1.5-hour examination consisting of 90 questions in fluoroscopy radiation protection and safety, and use of fluoroscopy and ancillary equipment.

3. **A Dermatology Supervisor and Operator Permit is REQUIRED if you use or supervise the use of X-ray therapy for the treatment of diseases and/or tumors of the skin.**

The Dermatology Supervisor and Operator Permit examination is a 1.5-hour examination consisting of 90 questions in dermatology radiation protection and safety, tumors of the skin, application and supervision of X-rays for treating diseases.

4. **For LIMITED Bone Density Supervisor and Operator Permit—PLEASE READ CAREFULLY:**

The LIMITED Bone Density Supervisor and Operator permit applies **ONLY** to use of the table-top bone density units for FINGERS, WRISTS, and HANDS. Submit the documentation of training provided from the authorized provider with your application and fee of \$55.95. **Please indicate on the application that you are applying for a LIMITED Bone Density Supervisor and Operator Permit.**

**NOTIFICATION OF EXAMINATION RESULTS**

1. The RHB will notify you by mail of your examination results within 30–45 days following the examination. Please allow 30 days from testing for results to be processed.
2. **The RHB cannot provide examination results over the telephone.**

**PRIVACY NOTIFICATION**

Pursuant to the authority found in Sections 100275 and 107110 of the Health and Safety Code and as required by Section 17520 of the Family Code, providing the social security number is mandatory. The social security number will be used for purposes of identification. The information may be provided to federal, state, or local agencies for law enforcement purposes. For information or access to your records, contact: Chief, Radiologic Health Branch—Certification, P.O. Box 942732, MS 178, Sacramento, CA 94234-7320, (916) 445-0931.